Mental Health and Substance Use - Policy and Data Sheet

This note summarises the key legislative, policy and data related to mental health and substance use. It is designed as a quick access guide for Strategic Planners who are analysing the strategic context for mental health and substance use planning.

This is an excerpt from the fuller Mental Health and Substance Use Options Appraisal document that can be found on our website. There are also other documents in this series including

- Integration in the context of Mental Health and Substance Use Services.
- Mental Health and Substance Use – Outlining the methodology for an options appraisal.
- Mental Health and Substance Use – Identifying and considering the options for change.

1 Key legislation and policy

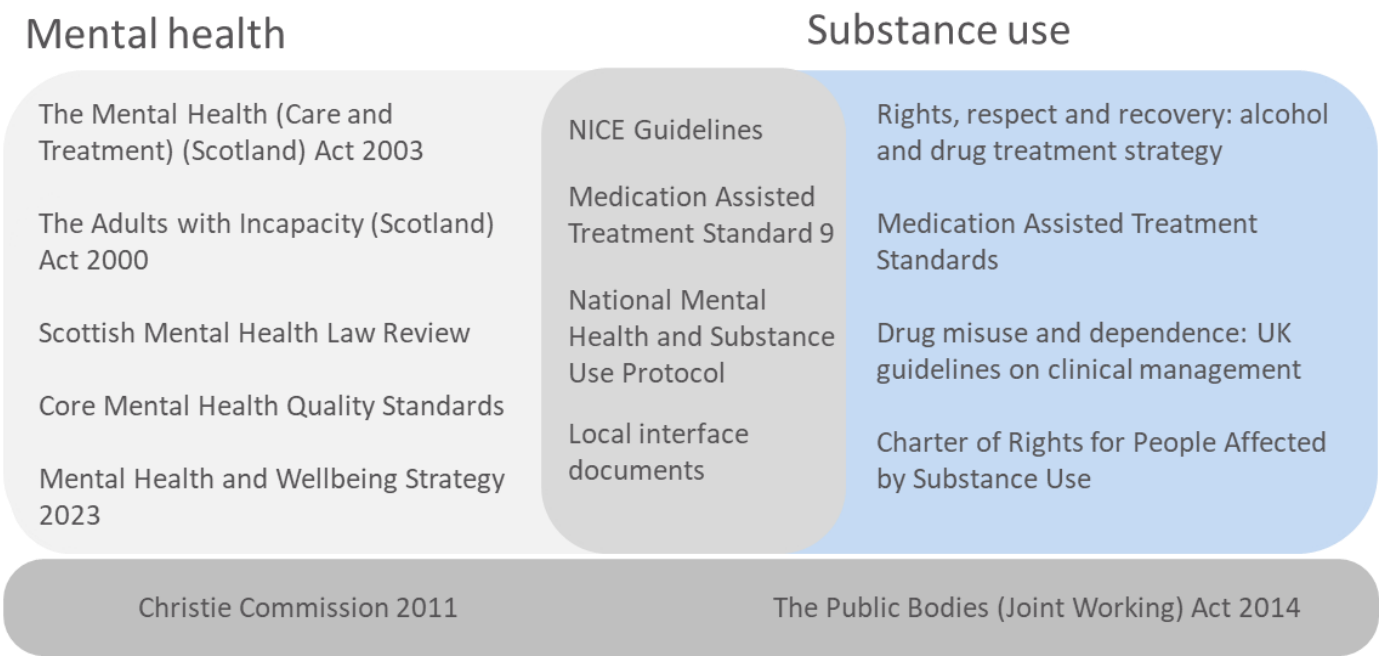

Figure 1 Legislation, policy and strategy relevant for mental health and substance use

Figure 1 above identifies the key legislation, policy and strategy relevant across mental health and substance use. There is a busy landscape of legislation, strategy and policy across mental health and substance use. Across these pieces of legislation and policy there is a clear direction on what a healthy system of support for people with mental health and substance use support needs should look like. Taken all together we see a shared ethos of:

- supporting preventative approaches
- connection across services (both in terms of pathways between primary and secondary services, but also across a range of social-emotional and condition specific services)
- understanding that people's health needs are interconnected and largely socially determined, and
- that management/leadership silos need to be broken down to support flexible responses at service level.

This ethos is built on a set of consistent principles including

- People should have their holistic needs met, facilitated by the service they are most in contact with.
- Direct referral into secondary services across mental health and substance use.
- Points of transition (including into non-statutory services) need to be planned.
- Ensuring continuity and that people don't fall through gaps requires the referral process to be underpinned by good relationships and joint decision making about appropriate referral.
- Establishing clarity over roles and responsibilities that allow for flexible responses to concurrent need.
- Developing resilience in the system through shared responsibility for risk.
- The need to understand and develop services that will support longer term recovery.

Despite a similar ethos and principles emerging across the legislative, policy and strategic landscape, there are still silos within those agendas in terms of aims, priorities, accountability, reporting and governance. There is a risk under the current context that the existing policy silos will further entrench operational silos. There is a lot of work happening at a local strategic level to try and bring together the different national asks into a coherent strategy, though this is still emergent.

2 Mental health

This section outlines the relevant mental health legislation, policy and strategy and mental health trends in Scotland.

2.1 Legislation, policy and strategy

There is a clear aim to break with the medical model within mental health, while also emphasizing the need for quality specialist services.

There is a focus on person centred care that supports relationships and transitions across services.

The Mental Health Core Standards have a specific section relating to transitions that centres on communication and flexibility.

Recently policy has been explicit in being more prescriptive around initiatives that help transfer care into the community – engaging with identified challenges more than previous statements of intent and high-level strategy.

The Mental Health Core Standards specify the need for multi-agency responses (away from the medical model), the importance of personal support networks (centred in the community), and a planned approach to collaboration between mental health services and other agencies.

Services need to be developed in a way that meets local need and provides people with a real choice around what care they would like to receive and how.

Key policy asks such as 'right care at the right time' are likely to involve more integrated approaches at a strategic level, away from service delivery, but the connection between planning and delivery is not made explicit within the policies.

2.2 Trends in Scotland

Both prevalence and acuity of mental ill-health appears to be rising in Scotland (in terms of general mental wellbeing and self-reported anxiety, depression, self-harm and attempted suicide).[1][2][3]

There appears to be a service gap, lacking appropriate mental health support for those who need it – with 78.4% of suicides contacting healthcare services prior to their death.[4]

Health inequality challenges are apparent in all mental health related measures of the Scottish Health Survey (most prominently in deprivation status)

There is a changing burden of inpatient mental health care, where people with acute mental health needs are being seen more in non-psychiatric wards, instead of psychiatric wards.

There are significant and worsening mental health staffing issues, a noted concern due to the link between absence of permanent staff and patient safety

Mental ill-health and health inequalities may continue to widen, given the current and anticipated economic environment.

3 Substance use

This section outlines the relevant substance use legislation, policy and strategy and substance use trends in Scotland.

3.1 Legislation, policy and strategy

Substance use policy widely includes other specialisms/service, reflecting the high level of comorbidity and complexity with people using substances. For example, the MAT Standards have specific standards relating to housing, primary care, mental health and advocacy.

Clinical good practice around medical interventions is central.

There is an additional focus on looking at prevention through addressing environmental drivers of substance use. Though with the latter, there is little specific guidance around how services and planners should engage with a prevention agenda.

Challenges in implementing the standards are linked to the above noted lack of legal duties relating to addictions; these duties do not note any special provision for people with addictions

[1] Scottish Public Health Observatory. Symptoms of common mental health problems in past few weeks [online]. 2024 [cited 2024 March 28]; available from: https://scotland.shinyapps.io/ScotPHO_profiles_tool/
[2] Scottish Public Health Observatory. Anxiety symptoms in past week [online]. 2024 [cited 2024 March 28]; available from: https://scotland.shinyapps.io/ScotPHO_profiles_tool/
[3] Scottish Public Health Observatory. Adults deliberately self-harming in past year [online]. 2024 [cited 2024 March 28]; available from: https://scotland.shinyapps.io/ScotPHO_profiles_tool/
[4] Public Health Scotland. Healthcare Contact Pathways od the ScotSID Cohort [online]. 2024 May 7; available https://publichealthscotland.scot/media/26817/scotsid-report-final-draft.pdf

and so there are noted challenges in engaging with these services to develop new pathways with substance use services.

The 2025 Charter of Rights for People Affected by Substance Use seeks to highlight where Humans Rights law, both nationally and internationally, should be applied to improve outcomes for people affected by substance use. It introduces specific duties, taking a rights-based approach, on services to ensure that human rights are being met.

3.2 Trends in Scotland

There is a clear impact of poverty on alcohol and drug misuse. The most deprived areas have the highest:

- Alcohol-related hospital admissions (104% higher than Scotland as a whole).[5]
- Alcohol-specific deaths (99% higher than Scotland as a whole).[6]
- Drug-related hospital admissions (146% higher than Scotland as a whole).[7]
- Drug-related deaths (149% higher than Scotland as a whole).[8]

Most drug-related admissions are held in general acute hospitals, proportionally very few are facilitated by psychiatric hospitals.

The latest estimate for those in Scotland with problem drug-use in 2015/16, aged 15-65 years old was 57,300 or 1.62% of the population. This is a higher proportion than that of any country in Europe.

Most drug-related deaths have more than one substance implicated, with opioids being most commonly found.

There is a significant population of those who are experiencing homelessness who have drug-related deaths.

Most drug-related deaths are accidental overdoses (95%).

Maternal substance-use is most prevalent in the under 20s age group and is on an increasing trend.

There is decreasing prescribing of methadone in Scotland.

4 Mental health and substance use

[5] Scottish Public Health Observatory. Alcohol-related hospital admissions [online]. 2024 [cited 2024 March 28]; available from: https://scotland.shinyapps.io/ScotPHO_profiles_tool/
[6] Scottish Public Health Observatory. Alcohol-specific deaths [online]. 2024 [cited 2024 March 28]; available from: https://scotland.shinyapps.io/ScotPHO_profiles_tool/
[7] Scottish Public Health Observatory. Drug-related hospital admissions [online]. 2024 [cited 2024 March 28]; available from: https://scotland.shinyapps.io/ScotPHO_profiles_tool/
[8] Scottish Public Health Observatory. Drug related deaths [online]. 2024 [cited 2024 March 28]; available from: https://scotland.shinyapps.io/ScotPHO_profiles_tool/

This section outlines the relevant policy surround mental health and substance.

- Key documents looking at concurrent need are centred on bringing together the condition specific strategies to understand how they relate within the context of co-occurring conditions; and setting direction for how services need to interact and collaborate.
- Concurrent mental health and substance use policy goes some way to describe what the connections across services should look like and triangulates the various requirements across services.
- The NICE Guidelines cover the key interfaces across statutory mental health and substance use services, as well as address some key operational challenges. Notably, there is explicit guidance that secondary mental health services should not exclude people based on their substance use.
- Local interface documents provide a more localised direction regarding things like communication flows and referral routes. These go some way to bring services together and address some of the key structural challenges that result in uncoordinated care.
- Where there are gaps in policy and strategy in outlining concurrent need it is in engaging with the complexities of the types of support people need, how mental health and substance use interact to impact people's lives, and how to understand the different dynamics of concurrent need.
- There is little specific national and local guidance that informs clinical decision making, set agreed roles and responsibilities and having agreed definitions of 'severe' and 'mild to moderate' mental ill health and substance use.
- Key features across legislation, policy and strategy with regards to how services should respond to concurrent mental health and substance use need include:
    - Clearer pathways across services, both to higher intensity services and broader social support. Supported by:
        - Information sharing.
        - Supporting/information while waiting.
    - Screening for a range of needs with ongoing recording of emerging information/needs. Supported by:
        - Agreed screening tools.
        - Staff supported to notice different needs and understand appropriate response.
    - Care coordination around a 'named professional'. Supported by:
        - Clear protocols for collaboration.
        - Incorporation of things outside of assessed need (holistic, non-clinical needs).
    - Support needs being provided 'in-house' where appropriate and available treatment needs to be informed by local need. Supported by:
        - Understanding of determinants of health.
        - Robust training and development.

- The National Mental Health and Substance Use Protocol brings these key features together into an articulation of good practice. Further to this, is expands on good practice to provide guidance around how to develop and implement new ways of working in these areas. In this way the Protocol synthesises existing policy and guidance in a way that aims to bridge the implementation gap.

5 Underpinning public sector context

This section outlines the relevant public sector context for mental health and substance use. In examining the context of the integration of mental health and substance use services, it is important to look at the entirety of legislation, policy and strategy driving the agendas across the entirety of services and sectors involved. Recent changes in and efforts to change health and social care in Scotland have been driven and guided by:

- The 2011 Christie Commission.
- The Public Bodies (Joint Working) Act 2014.

There is national strategy level focus on prevention and a more flexible use of resources. They established the need for a shift in operating models within the NHS, from the acute medical model of delivering and the new public management approach to planning; and towards engaging with complex needs and emphasising personal outcomes as a key system measure.

There is an emphasis on socio-economic drivers of health and how the healthcare system needs to change to respond to these, supported by better planning/oversight across a whole system, increased community care and an investment in prevention.

The Joint Bodies Act aimed to support the above ambitions by formally integrating organisations and budgets. Implementation of the principles behind these two national drivers has been hindered by:

- Challenges linked to having to transform systems within existing resources.
- The sustained primacy of 'throughput and output' as the focal points of measurement within monitoring, scrutiny and what is considered a successful model of care.